

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-050052

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

12426

STATE FILE NUMBER

FILED DEC 20 1963

| | | | |
|---|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> | | c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Christian Hospital</u> | | d. STREET ADDRESS (If outside, give location) <u>1531 Hornsby Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>GUSTAF F. WAGNER</u> | | 4. DATE OF DEATH <u>December 14 1963</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/2/1895</u> |
| 9. AGE (last birthday) <u>68</u> | | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Bldg.</u> | |
| 11. BIRTHPLACE (City and state or country) <u>Hamburg Germany</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13a. FATHER'S NAME <u>Johannes Wagner</u> | | 13b. MOTHER'S MAIDEN NAME <u>Marie Drewes</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Stella Wagner</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Stella Wagner 1531 Hornsby Ave.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Encephalomalacia due to Ter-estrial Arterio-sclerosis</u> DUE TO (c) <u>Hypertensive heart disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>443 X</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>See below</u> <u>Unknown</u> <u>Unknown</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | 20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | |
| 21. I attended the deceased from <u>Dec 6, 1963</u> to <u>Dec 14, 1963</u> and last saw him alive on <u>Dec 13, 1963</u> Death occurred at <u>3:30 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | 22a. SIGNATURE (Degree or title) <u>D. B. Tjallat M.D.</u> | |
| 22b. ADDRESS <u>4222 N. Grand</u> | | 22c. DATE SIGNED <u>12-16-63</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>12/17/63</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u> | |
| 24. FUNERAL DIRECTOR ADDRESS <u>JOHN STYGAR & SON - 5541 RIVERVIEW BLVD.</u> | | 25. DATE RECD. BY LOCAL REG. <u>DEC 16 1963</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Lead Smith M.D.</u> | | | |

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

STANDARD-883

ASASL

ECUI

2000

Dr. J. H. Black
Lass H. Black

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. H. Black
Licensed Embalmer No. 3980

P. O. Address St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.